Conference Committee Report on
House Bill No. 963 / Senate Bill No. 937

The House and Senate Conference Committee appointed pursuant to motions to resolve the differences between the two houses on House Bill No. 963 (Senate Bill No. 937) has met and recommends that that all amendments be deleted:

The Committee further recommends that the following amendment be adopted:

by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-7-3302, is amended by deleting the entire section and substituting the following language:

(a) A health insurance carrier shall provide notice to a provider of any material change made in the sole discretion of the insurance carrier to the carrier's previously-released provider manual or a payment policy at least sixty (60) days prior to the effective date of the change, and the health insurance carrier shall ensure that any such material change is clearly identified in the following manner:

(1) Disclosing or identifying the change in the provider manual through the use of bold print or a font, or both, the bold print and a font being the same or larger size as the font generally used throughout the provider manual or payment policy;

(2) Disclosing or identifying the change in the payment policy through the use of a separately categorized communication associated with quarterly or annual updates to the provider manual or monthly newsletters; and

(3) Any disclosures required under subsections (1) or (2) may be distributed via:

(A) Compact discs or other downloadable electronic media;

(B) An Internet web-accessible section associated with a web-accessible current version of the provider manual or payment policies; or

(C) Written communication sent via electronic mail or mailed directly to the provider.

(b) Notwithstanding any law to the contrary, nothing in this part shall apply to the TennCare program or any successor Medicaid program provided for in title 71, chapter 5; the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11; the Access Tennessee Act of 2006, compiled in title 56, chapter 7, part 29; any other plan managed by the health care finance administration division of the department of finance and administration or any successor division or department; or the group insurance plans offered under title 8, chapter 27; or a contract between a health care provider and the state or federal government or their agencies for health services provided through a program for Medicare.

SECTION 2. Tennessee Code Annotated, Section 56-7-1013, is amended designating the existing language as a new subdivision (1) and by inserting the following as a new subdivision (2):

(2) "Fee schedule" means a list of maximum reimbursement amounts assigned to specific codes and used by a health insurance carrier pursuant to a contract between a health insurance carrier and a healthcare provider to calculate payments paid to the provider for therapies, procedures, materials, and other services delivered to enrollees.

and by deleting the entire subsection (c) and substituting instead the following language:

(c)

(1) A health insurance carrier shall provide notice of and identify any change to a provider's fee schedule at least ninety (90) days prior to the effective date of the change. The notice and identification required by this subdivision (c)(1) shall be sent to a dedicated email address or as otherwise stipulated in the contract between the provider and the health insurance carrier.

(2) A health insurance carrier shall not require any hospital, by contract, reimbursement or otherwise, to notify the health insurance carrier of a hospital inpatient admission within less than one (1) business day of the hospital inpatient admission if the notification or admission occurs on a weekend or federal holiday. Nothing in this subsection (c) shall affect the applicability or administration of other provisions of a contract between a hospital and health insurance carrier, including, without limitation, preauthorization requirements for scheduled inpatient admissions.

(3) This subsection (c) shall not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar organization.

and by adding the following as new subsections:

(f)

(1) Within ten (10) business days of receipt of a valid request from a provider, a health insurance carrier shall deliver to the provider at the provider's dedicated e-mail address that provider's fee schedule, free of charge, in either a partial or full version as requested by the provider; or

(2) A health insurance carrier may provide access to a provider's fee schedule on a secure web site, so that the provider may access the fee schedule at any time throughout the term of the provider's contract with the health insurance carrier. Nothing in this subdivision shall require a health insurance carrier to provide a fee schedule via a web site.

(g)

(1) No health insurance carrier shall make a change or changes to a provider’s fee schedule except as follows:

(A) Up to one (1) tie during a consecutive twelve-month period. After a health insurance carrier makes a change or changes to the provider's fee schedule, it is prohibited from doing so again for at least twelve (12) months following the effective date of the change or changes; or

(B) If a health insurance carrier and a hospital agree to the change or changes in writing;

(2) Subdivision (c)(1) and subsection (g) do not apply to the following changes to a fee schedule:

(A) Any change in a provider's fee schedule due to a change effected by the federal or state government to its healthcare fee schedule, if the provider and health insurance carrier have previously agreed that the provider's fee schedule is based on a percentage or some other formula of a current government healthcare fee schedule, such as Medicare;

(B) Any change in a provider's reimbursement for drugs, immunizations, injectables, supplies, or devices if the provider and health insurance carrier or pharmacy benefits manager as defined by 56-7-3102 have previously agreed that any reimbursement for drugs, immunizations, injectables, supplies, or devices will be based on a percentage, or some other formula, of a price index not established by the health insurance carrier, such as the average wholesale price or average sales price;

(C) Any changes in the provider's reimbursement for drugs, immunizations, injectables, supplies or devices if the provider and the health insurance carrier or pharmacy benefits manager as defined in 55-7-3102 have previously agreed to any reimbursement for drugs,

immunizations, injectables, supplies or devices in accordance with 56-7-3104 and based upon maximum allowable cost pricing as regulated by 56-7-3101 and 56-7-3106;

(D) Any change to Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, International Statistical Classification of Disease and Related Health Problems (ICD Codes and other coding sets recognized or used by Centers for Medicare and Medicaid Services (CMS) that a health insurance carrier utilized in creating a provider's fee schedule;

(E) Any change to revenue codes as established by the National Uniform Billing Committee (NUBC); and

(F) Any changes in a provider's fee schedule due to one (1) or more of the following if previously agreed to in a provider's agreement with a health insurance carrier:

(i) Payments made to the healthcare provider by the health insurance carrier or payments made to the health insurance carrier by the provider that are based on values or quality measures explicitly described in the written agreement between the provider and the health insurance carrier intended to improve care provided to the health insurance carrier's members;

(ii) Escalator or de-escalator clauses;

(iii) Provisions that require adjustments to payment due to population health management performance or results; or

(iv) Any arrangements, initiatives, or value-based payments relating to or resulting from the implementation or operation of the Tennessee Health Care Innovation Initiative.

(h) Nothing in this section shall apply to an enrollee's benefit package, or coverage terms and conditions, unrelated to application of fee schedules and reimbursements, including, but not limited to, provisions regarding eligibility for coverage, deductibles and copayments, coordination of benefits, and coverage limitations and exclusions.

(i) Nothing in this section shall apply to any entity that is subject to delinquency proceedings and for which the commissioner of commerce and insurance has been appointed receiver, or any entity placed under administrative supervision by order of the commissioner pursuant to the Insurers Rehabilitation and Liquidation Act, compiled in chapter 9 of this title.

(j) Nothing in this section shall apply to the TennCare program or any successor Medicaid program provided for in title 71, chapter 5; the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11; the Access Tennessee Act of 2006, compiled in title 56, chapter 7, part 29; any other plan managed by the health care finance administration division of the department of finance and administration or any successor division or department; or the group insurance plans offered under title 8, chapter 27.

(k) Notwithstanding anything in this section to the contrary, this section shall not apply to any contract amendment that is made due to a change in federal or state law.

(l) Nothing in this section shall apply to any contract between a health insurance carrier and a healthcare provider for items or services to be provided for individuals covered by any Medicare Advantage, Medicare Select, Medicare Supplement, Medicare and Medicaid Enrollees (MME), Medicare Dual Special Needs, and Medicare Private Fee for Service; or the state, local government, and local education insurance plans established under title 8, chapter 27.

(m) Notwithstanding any law to the contrary, nothing in this part shall apply to the TennCare program or any successor Medicaid program provided for in title 71,

chapter 5; the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11; the Access Tennessee Act of 2006, compiled in title 56, chapter 7, part 29; any other plan managed by the health care finance administration division of the department of finance and administration or any successor division or department; or the group insurance plans offered under title 8, chapter 27; or a contract between a health care provider and the state or federal government or their agencies for health services provided through a program for Medicare.

SECTION 3. This act shall take effect January 1, 2018, the public welfare requiring it, and shall apply to all contracts entered into or renewed thereafter.

Senator Bo Watson	Representative Cameron Sexton
Senator Mark Green	Representative Charles Sargent
Senator Lee Harris	Representative Joe Pitts